

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 012005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/13/2013
NAME OF PROVIDER OR SUPPLIER RN & ALLIED SPECIALTIES		STREET ADDRESS, CITY, STATE, ZIP CODE 1302 N MERIDIAN SUITE 350 INDIANAPOLIS, IN 46202		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	<p>Initial Comments</p> <p>This visit was a state Home Health complaint investigation survey.</p> <p>Complaint number: IN00123797 - Unsubstantiated: Lack of sufficient evidence.</p> <p>Survey date: March 13, 2013</p> <p>Facility number: 012005</p> <p>Surveyor: David Eric Moran, BSN, RN, Public Health Nurse Surveyor</p> <p>RN & Allied Specialties is in compliance with the Indiana State Rules for home health licensure 410 IAC 17-13-1 as related to this complaint.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 18, 2013</p>	N 000		

Indiana State Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

NFLN11

If continuation sheet 1 of 1